

Harvard Medical Alumni Bulletin

Volume 20, Number 4 June, 1946

Annual Meeting — See Page 120



In the severe depressions of the menopause marked by apathy and psychomotor retardation

Many women in the climacteric period develop a true reactive depression, characterized by apathy, psychomotor retardation and despondency.

• This depressive syndrome is frequently progressive; and, unless promptly and effectively treated, may seriously impair the patient's normal capacity for useful living.

• In such cases, Benzedrine Sulfate helps to reawaken mental alertness and optimism, and to restore the savor and zest of life—especially when administered in conjunction with such fundamental measures as electric shock and estrogenic therapy.

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VITAMIN D has been so successful in preventing rickets during infancy that there has been little emphasis on continuing its use after the second year.

But now a careful histologic study has been made which reveals a startlingly high incidence of rickets in children 2 to 14 years old. Follis, Jackson, Eliot, and Park* report that postmortem examination of 230 children of this age group showed the total prevalence of rickets to be 46.5%.

Rachitic changes were present as late as the fourteenth year, and the incidence was higher among children dying from acute disease than in those dying of chronic disease.

The authors conclude, "We doubt if slight degrees of rickets, such as we found in many of our children, interfere with health and development, but our studies as a whole afford reason to prolong administration of vitamin D to the age limit of our study, the fourteenth year, and especially indicate the necessity to suspect and to take the necessary measures to guard against rickets in sick children."

*R. H. Follis, D. Jackson, M. M. Eliot, and E. A. Park: Prevalence of rickets in children between two and fourteen years of age, Am. J. Dis. Child. 66:1-11, July 1943.

MEAD'S Oleum Percomorphum With Other Fish-Liver Oils and Viosterol is a potent source of vitamins A and D, which is well taken by older children because it can be given in small dosage or capsule form. This ease of administration favors continued year-round use, including periods of illness.

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Volume 20 June, 1946 Number 4

Medical School Notes

VETERANS' ADMINISTRATION

A sweeping change in the professional management of the Veterans' Administration hospitals is under way. This reorganization stems from the work and ideas of Dr. Cutler, Dr. Hawley, and the other physicians in the Veterans' Administration who are directly concerned with postwar plans.

Briefly, the plan envisages an association between Veterans' Administration hospitals and medical schools which will make it possible to conduct the care of patients and the teaching of the resident staffs in these hospitals on a standard of excellence comparable with that to be found in the best civilian institutions.

The Veterans' Hospital in West Roxbury has been chosen as the first for "reconversion" in the Boston area. A Dean's committee has been set up jointly from the three Boston medical schools. Dr. Donald Anderson of Boston University, Dr. Dwight O'Hara of Tufts, and Dr. Sidney Burwell of Harvard constitute this committee with Dr. Dale Friend as Secretary. To help in the work of this committee, one advisor each from medicine and surgery has been appointed from each school and a subcommittee on neuropsychiatric matters consisting of representatives from the schools and from the State Department of Mental Health.

PROFESSIONAL APPOINTMENTS

Under this committee appointments are to be made in several different categories of professional qualification. Consultants who are specialists in their field, certified by their Board, and well qualified to teach will form the senior active group. Veterans will be given preference for these appointments unless no qualified veteran is available. These men will teach at the Veterans' Hospitals, conduct clinics, make ward visits, be available for consultation and advice on long-term planning. In addition to this group a number of younger men will be appointed as attending physicians and surgeons. These men will be in the age group whose medical appointments are those of Instructor or Associate.

These men will be more closely associated with the conduct of the wards and care of patients than will the consultant. They will be directly in charge of the wards, will make rounds, teach the house staff, and in the case of surgeons, carry out operations when necessary.

Under the direction of these men, the resident staff will function much as in a civilian hospital. They must be graduates of an accepted medical school and must be planning their training in the direction of Board certification. These men must be veterans of World War II. The residencies involve a three year appointment, or more, if desired. The salary is to be approximately $3500 per year, though later this may be divided into a graduated scale with a lesser salary being given during the first year of residency.

In addition to these categories, the Chief of Medicine and Chief of Surgery as well as Chiefs of the other major divisions are appointed to full-time positions. The duties of these men will be analogous in every way to the Chiefs of Service at our Boston hospitals. At the present time, Dr. Richard Warren has been appointed Chief of Surgery and Dr. Thomas Warthin, Chief of Medicine. The appointments in Pathology and X-ray are still unfilled. Drs. Warren and Warthin are making their resident staff appointments at the present

time and the system will be in full operation in the very near future.

AREA CONSULTANTS

Further professional direction is provided through national and branch consultants. These consultants, in the case of the Boston area, are assigned to the New England states and include such men as Dr. Richard Schatzki in Roentgenology, Dr. Tracy Mallory in Pathology, Dr. Arthur Watkins in Physical Therapy, Dr. Howard Sprague in Cardiology, Dr. Bradford Cannon in Plastic Surgery, Dr. Alexander Marble in Medicine, Dr. Edwin Cave in Orthopedics, Dr. James C. White in Neurosurgery, and Dr. Donald King in Chest Diseases. This list is not complete and other appointments in this category will be made at a later date. Eventually, in the Boston area alone, there may be training space for as many as fifty residents under the Veterans' Administration. Needless to say, approval of these hospitals from the specialty boards is essential to the success of the plan; yet such a plan cannot be given approval until it is observed in actual operation.

Professional organizations of this type are being set up all over the country. The first to be in actual operation is the Hines Hospital in Illinois, in which such a scheme of coordinated training association with teaching institutions has been in operation since February of this year.

It is hoped that the Cushing Hospital in Framingham may be brought into this scheme as well as Veterans Administration hospitals at Bedford and Rutland Heights. The West Roxbury Hospital has 500 beds, 120 of which are surgical. The present plan envisages one resident for every 30 patients.

The patients cared for under this scheme will be veterans of any war and preference will be given to service-connected disabilities.

Undergraduate teaching of medical students at these institutions has not yet been considered, but it is conceivable that the development of such institutions as these over the country may increase considerably the number of beds available for teaching in medical schools.

SALARIES

The incomes of doctors involved in the Veterans' Administration scheme will range from a $3500 per year salary for residents, up to $9000-$11,000 a year as salary for the Chief of Service. The consultants' salaries will occupy the general range of $6000 per year. It is naturally important to enquire what relation these incomes bear to the average professional incomes received throughout this country by well qualified men in practice. The reason for this is clearly that the Veterans' Administration Hospitals cannot compete for well qualified men in their top positions unless they can pay them a salary which will be as rewarding as the fruits of private practice.

In 1943, the average gross income of a group of specialists in the country at large ranged around $14,000 per year—the highest average income for a single large group was to be found in the general surgeons where the average income was $20,733.

One may well argue that 1943 constitutes an exception and that all doctors were busier than usual. This is borne out by comparison with the statistics for 1935 where we find that the average gross income of all physicians throughout the country was $6000 per year and of surgeons $10,000 per year.

The above figures are all figures for gross income and the average deduction for expenses runs in the range of 30 per cent of the gross, cutting the average income for the country as a whole, computed as net income, down to $4000 per year for all physicians and approximately $7000 per year for surgeons.

It is thus clear that the salaries which the Veterans' Administration is offering should be adequate to attract well qualified and able specialists to the consultant categories and well qualified younger men as residents, attending men, and Chiefs of Service.

HOUSING

The housing of the postwar medical students is a sore point, especially with those postwar medical students who have no place to be housed! The Medical School is to receive its share of new units being set up for the University in Cambridge such as the buildings which have already been put into use on Jarvis Field. Preference is given to students who already have two or more children. It is very probable that on this basis the medical students will win out very rapidly. Any student who wishes to make enquiries in this regard should do so at the Bureau in charge of housing which is in Straus Hall in Cambridge.

We see by the papers that the Brunswick Hotel is to be taken over by the University. What with the subway beneath running out to Longwood Avenue, one can but speculate on the convenience of this arrangement were it to be used for the married men at HMS!

NEW APPOINTMENTS

Dr. Myles P. Baker has been made physician to students, and in this position succeeds to a long line of illustrious clinicians who have occupied this position at one time or another in their career.

Dr. Baker graduated from Harvard College in the class of 1922 and from the Medical School in 1928. His hospital training was taken at the Massachusetts General Hospital where he was a house pupil on the East Medical Service from the time of his graduation from medical school until 1930. Following this, he had an Assistant Residency at the Johns Hopkins Hospital in medicine, during 1930 and 1931.

From 1932 until his entry into the Armed Forces in 1942, Dr. Baker was engaged in the practice of internal medicine in Boston. He was an Assistant in Medicine and an Assistant Physician on the Medical Service at the MGH, and was active in teaching the third year students their section work in Internal Medicine.

In April 1942 he was commissioned a Major in the Army Medical Corps and joined the 105th General Hospital, leaving for active service overseas in May, 1942. During the two years in which this hospital functioned in Australia, Dr. Baker was a Section Chief on the Medical Service. Subsequently he worked as an Assistant Medical Consultant in various New Guinea bases and during the winter of 1944-1945 was made Chief of the Medical Service of the 54th General Hospital in Hollandia, Dutch New Guinea. He was promoted to Lt. Colonel and later served as an Assistant Medical Consultant in Manila.

He returned to the United States in 1945 and became Medical Consultant to the 6th Service Command until his discharge in December of last year.

Having now returned to civilian practice, he will take up his duties as Physician to Students at the Medical School along with his private practice in Internal Medicine. His present appointment at the Massachusetts General Hospital is that of Associate Physician on the Medical Service.

WORTH HALE

In June, 1943, when Doctor Worth Hale retired as Emeritus from his Professorship in Pharmacology in the Harvard Medical School, which he had so long distinguished, he patriotically consented, at the peak of the war exigency, to continue for an indeterminate period in his position as First Assistant Dean of the Faculty of Medicine and Chairman of the Committee on Admissions—the position in which for a quarter-century previously he had endeared himself to the academic generations of medical students. Throughout the war Doctor Hale has continued to occupy this strategic post and in it he has discharged an invaluable service to the School and to medical education as liaison officer between Harvard and the Army and Navy in the difficult and expert function of selecting candidates for admission. Already he has been connected with the Administration longer than any other Dean. Moreover,

he has maintained and increased his reputation as perspicacious and unerring judge, as sagacious counselor, and as the sincere and sympathetic friend of all students.

Now that victory has been won and the School is returning to its peace-time status, Doctor Hale is at last to enjoy well-deserved release from his prolonged labors. In this surcease, the affection and esteem of hundreds of his comrades, young and old, will follow him far into the future. "Finis coronat opus," and in his latest achievement Doctor Hale has placed a fitting crown on his long years of service. To him will remain always the devotion and loyalty of all his associates and to us the inspiration of his rare personality. Worth Hale has proved himself the able scholar and teacher, the skilled and tactful administrator, the true humanist in medicine.

Dr. Dale Friend has been appointed Assistant Dean to assist Dr. Worth Hale until Dr. Hale retires this July, and then to take over his many duties.

Dr. Friend graduated from the Medical School in 1935 and after that took a medical internship at the Brigham Hospital, following which he was appointed an assistant resident. He then became Research Fellow and worked in Biochemistry under Dr. Hastings and then as a Moseley Traveling Fellow studied Biochemistry at University College in London. Here he worked under Sir Thomas Lewis and Professor Harrington in immunochemistry.

He returned to this country in the fall of 1939 and was appointed an Instructor in Pharmacology which position he occupied until he left for the Army in 1941 with the 101st Medical Regiment. In this organization he occupied the position of Lt. Colonel and Commanding Officer. His regiment was soon sent to very active service indeed and Dr. Friend was promoted to Colonel during combat on Guadalcanal.

He was decorated with the Legion of Merit for his work on Guadalcanal and returned to this country to help organize two evacuation hospitals. With one of these institutions he returned to the wars, but this time in the ETO where he saw service in England, France, Germany (with the Third Army) and finally in Austria. While in Austria, he witnessed the surrender of the Hungarian fleet on the Danube River.

His group was amongst the first into the Mauthausen Concentration Camp and had first hand contact with the conditions there. His hospital then became a part of the Army of Occupation and late last fall he returned to this country.

It is clear that Dr. Friend's past accomplishments eminently suit him for the job of successor to Dr. Hale.

ALUMNI OFFICE

After a war-time move to the School of Public Health, enforced by the necessity of making room in Building A for Major Rosengard's office, the Alumni office has moved back to Building A. Here, the office, under the direction of Mrs. K. B. Wilson, is available for news and addresses of alumni, editorial work on the BULLETIN, and such other duties and services as the Alumni Association may desire.



Indian Neurological Interlude

Derek Denny-Brown

Tropical medicine has been the temporary occupation of many during the last four years, but an account of the experiences of a neurologist in that enigmatic country, India, may be of interest. The writer had an unusual opportunity, as Consultant in Neurology to the British Army in India and South East Asia, to form impressions of a multitude of places and problems in the period from May to December 1945.

The month of May in India is the beginning of "hot weather"—the long dry days when the temperature varies between 105 and 116 and falls to 80 to 95 at night for three months on end. The hot sun beats mercilessly down on man and beast, the hard baked soil gives nought but dust, and only the flowering Mohur tree gives any beauty to a cracked, parched earth. Then with a startling suddenness the clouds come, having swept slowly across the continent from the Bay of Bengal. The monsoon has arrived. Tropical downpours follow rapidly on each other for three months, and the steaming earth sprouts all manner of green things in the course of some hours and bears three or four crops in the wet season. The steamy heat is even more unpleasant than the dry season. By November the temperature at last drops until coastal places like Bombay become as cool as Philadelphia is in July and August, while in the great northern plains the nights become cold as bitter winds from the Himalaya sweep south.

The predominant impression of India is of myriads of people—in every populated place, in every railroad station, in every vehicle; all shades of color, from near black to sallow pallor, but mostly brown, and many of handsome feature. Two thousand years before Christ the Indus civilization was as highly developed as that of the Indian bazaar of today. All through India, but particularly in the north, proud noses and lofty brows proclaim the absorption of a succession of alien invaders—from the invasion of the Aryans 1000 B. C., whose social development became Hinduism, then of the Greeks with Alexander the Great who entered India in 326 B. C. and left his generals as satraps for another 200 years, followed by the series of Buddhists, then Persian, overlords that reigned off and on for another 1000 years. Finally, the Mughuls—Tartars from the north, set up an empire of great architectural beauty from 1000 to 1600 A. D. This conglomeration of peoples, now controlled through a government that is mostly Indian, is held together only by the dominance of Britain, soon to be withdrawn.

By 1941 India had sent every possible weapon, and other military stores, and all but one or two brigades of infantry and cavalry, both Indian and British, to the forces opposing Rommel in the Middle East. The military hospital system was organized in a series of base hospitals to receive the flow of casualties into the west coast ports of Karachi and Bombay. The advance of Nippon in early 1942 through Indo-China, Siam, and thence to Burma was "the war on a second front" that Britain could ill-afford, and for a time was disastrous to such forces which still remained. Thousands of dysenteric and malarious sick flowed over the mountain passes from Burma and the inadequate and slowly reinforced hospitals of Bengal and Bihar were flooded until dying men were laid in rows in the open fields near Ranchi. The Japanese invader did not, however, come on, and gradually, in the face of every conceivable kind of obstacle, the front against the Japanese was built up. The flow of casualties became east to west. All supplies of concrete went into making airstrips, hospitals were constructed of bashas (tundra grass on poles), equipment



The author at Attock where the Indus river passes swiftly through a rocky defile. Its narrowness here provides the only crossing place for hundreds of miles, used by invaders from the northwest for centuries. The ancient fortress is on the right.

was made in the bazaars, and at first the evacuation of casualties was by litter over mountain paths, to river boats that sailed for many days down the Bramahputra to reach their destination.

By the time I reached India the British forces facing Japan numbered over three and a half million men. These were aided by an American force, Merrill's Marauders, and in the north by a Chinese army, largely officered by Americans. In addition, a tremendous American engineer organization was busy building the Stillwell and Ledo Road, and the magnificent American Army Air Transport Force was running the supply of munitions from Bengal over the "hump" to China.

My own appointment was concerned solely with the three and a half million British forces. About two million were from the United Kingdom; the others, a million and a half, were Indian natives, all volunteers, officered by both British and Indians. In addition, there were a few African native troops. The whole was financed by the United Kingdom, aided by great quantities of lend-lease equipment and food from this country. It is important to realize that India, though containing a few very rich Indians, is a desperately poor country and without the working capital to finance anything like the effort that all this demanded.

The Indian Base and Field Hospitals were raised in India and, like the other Indian units in the Army, had a mixture of Indian and British Officers, Indian nurses, and some British nurses. The British Base and Field Hospitals, having been raised in Britain, had an all-British staff. All were under the same command and the British medical officers were interchangeable. Many Indian hospitals had an all-Indian staff, others a mixture, and it was not uncommon for British Officers to serve under an Indian commanding officer, just as there were Indian Brigadiers in the field having British fighting units under their command. Usually British cases were treated in British hospitals, but if none were near, they were admitted and treated in Indian hospitals by Indian doctors. This was by no means uncommon. Thus it was that some of the executive officers with whom I worked were Indian, some British; the head of the whole organization of medical supplies, for instance, being an Indian.

These armies were divided into *South-East Asia Command,* the fighting force under the over-all Supreme Command of Lord Mountbatten, and *India Command,* the Base for all supplies, training, hospitalization, and the starting point of landing operations, under General Auchinlech, under the Supreme control of the Government of India.

Over 200,000 hospital beds served the whole area, to receive casualties from the Burma front, in base hospitals, and hospitals for the areas for jungle and other training scattered throughout India, besides convalescent units in the hills. The sickness rate was high, especially in the earlier years. From 1939 to 1945 three and

a half million sick and wounded were treated.

In this medical organization the function usually allotted to an Inspector of Hospitals had gradually become divided between a corps of Consultants, Consultants in Medicine, Surgery, Psychiatry, Otorhinolaryngology, Anaesthetics, Venereology, Ophthalmology and Neurology inspected and continually reported on the state of these specialties, supervised the advancement, posting and replacement of specialists in their own subject throughout the system, recommended suitable directives and changes to meet the fluctuating situation. When two specialties overlapped the corresponding Consultants collaborated in the task, so that by arrangement with the Consultant in Surgery, the Consultant in Neurology was responsible for three mobile neurosurgical units in the field and a neurosurgical center at the Base, two peripheral nerve injury centers and three paraplegic centers. In neurological medicine there were three Advisers in Neurology, each supervising one area, a neurological center of 200 beds under one of my Advisers, a neuropathological research team, and the Consultant besides supervising these was made responsible for the general handling of poliomyelitis, neuritis, meningitis, sciatic pain, myelitis, cysticercosis, leprosy, neurosyphilis, trypanosomiasis, and collaborated in reports on cerebral malaria and heat stroke throughout the whole area.

It was, of course, first essential to see what was going on in my bailiwick and for six months I toured steadily inspecting hospitals, doing ward rounds to see all cases I was interested in, making notes, and usually travelling by night. These tours, which covered all India north to the lower ranges of the Himalaya, south to Ceylon, east to the slopes of the Arakan, west to the border of Afghanistan, brought a wealth of clinical experience one can never forget. It also brought an overdose of the East and its mysticism, its impracticality, and the deviousness of its mental outlook. By chance I saw cases of Asiatic cholera in a civilian outbreak and was impressed by the resistance of Eastern people to Western ideas of sanitation and general hygiene. Only those who have travelled the dusty plains of India in the crowded wartime trains know the discomfort of journeys of days and nights with 10 to 16 in a 4-berth compartment. Only those who have experienced the aggravated obstructionism of "Babuism"—the ultra-red tape of the native clerks, know the exasperations of administrative India. Some of the hilly parts of India are extremely beautiful, and there are many wise and sagacious Indians, but these are a rare distillation of the teeming millions on the hot plains. It is there that the solution of one of the most difficult political problems of coming years must be sought.

The highlights of this clinical experience were, for me, first, the very different composition of neurological diseases in India as compared with Anglo-Saxon countries; second, certain observations on the epidemiology of poliomyelitis; and, lastly, the varied nature of neurological disorders associated with malnutrition.

With regard to the distribution of neurological diseases I would first mention multiple sclerosis of which I could not find one single case affecting an Indian. Several cases of amyotrophic lateral sclerosis were seen, of myopathy, and some with cerebral tumor. Combined system disease appeared to be rare. Ruptured intervertebral disc was extremely rare, though common in European nationals, an observation that tempts reflection on the exercise which Eastern peoples give the vertebral column by carrying weights on the head. Classical causalgia was common, rising to over 2% of cases of nerve injury, was markedly influenced by air temperature, and sympathetic block or sympathectomy provided relief in a percentage one would not previously have believed possible. A large percentage of cases of jungle sore developed diphtheritic peripheral neuritis, usually traceable to the presence of diphthe-

ritic carriers in the neighborhood, and secondary infection of the jungle sores. The primary infection is usually a spirillum. Cardiac affection in these cases was extremely rare, though I saw one such, and in its absence early exercise was found to be extremely beneficial for the neuritis. Syphilis in Eastern peoples is very common and the neurological lesions almost always of meningovascular type (myelitis, hemiplegia, etc.). I saw one case of tabes in an Indian national but tabes is excessively rare, and general paresis unknown.

Spontaneous cerebrovascular disease in young people not showing clinical or serological evidence of syphilis was not uncommon, and generally had a good prognosis. In two such cases which came to autopsy an arteritis of non-syphilitic but unknown etiology was found to affect a cerebral vessel. No other change was found except an acute streptococcal tonsillitis in one case. There was no endocarditis.

Two cases of acute ascending myelitis closely resembling the dumb rabies reported by Hurst and Pawan in Trinidad in 1931 were seen and proven by autopsy. The material from two authentic cases of neuropticomyelitis was examined.

Among these varied conditions was also the interesting problem of cysticercosis. The cerebral infection which has a latent period of about two years, is well known in Britain in soldiers returned from service in India, though officers and nurses are almost immune. I saw two examples of the early stage of the disease, with nodules in the muscles, in India, and a number of the late cases both in Indians and Europeans, with the epilepsy and cystic calcification, and feel certain that it is likely to occur in some returned American soldiers. There is evidence that consumption of pork in Indian bazaars, followed by auto-infection from the resulting tape worm, was the mechanism of infestation with the cystic stage. Kala-azar was also acquired by some British and American soldiers but its cerebral manifestations are exceedingly rare, and it is to be thought of as a possible cause of relapsing pyrexia with enlarged spleen. A sternal puncture will settle the diagnosis. I saw only one European with leprosy, though the more benign types are common in the Indian national.

The Indian Pioneer Corps recruited from the lower castes had some interesting epidemiological problems arising chiefly from their habits of sleeping in clumps in spite of the provision of individual mattresses. As might be expected, meningococcal meningitis was common, and in line with universal experience in all armies the difficulty was to get patients to report sick at a sufficiently early stage to allow effective treatment of fulminating cases. In addition the extremely hot weather made it difficult to maintain adequate urinary output to avoid renal damage from the use of the less soluble sulfa drugs. The more soluble mono- and dimethyl-sulfa-diazine became generally available only in 1945, and the latter was being rapidly adopted for general use in pyogenic meningitis under the name of "sulphamezathine." A small but interesting series of cases in the same hospital, reported to be refractory to treatment with the drug and to exhibit anomalous fluid findings, was demonstrated by the author to be mumps meningitis, mumps being prevalent in that camp at the time.

The most remarkable change in the attitude of the European to clothing in hot climates has occurred in the last five years. It is now realized that heatstroke has a direct relationship to the amount of exercise in high temperature in unacclimatized persons. With indoctrination of new arrivals, proper salt and fluid intake, sensible light clothing (or under extreme conditions nothing above the waist), heatstroke was restricted almost entirely to new arrivals who had omitted to take precautions. The solar topee, high collars, and the cholera belt, beloved of all the Victorian era, have gone never to return. Severe heatstroke is a dangerous illness, nevertheless, and I saw some fifteen cases with their characteristic prolonged hy-

perpyrexia. An interesting cerebellar syndrome sometimes follows it, resembling cases of cerebellar atrophy. This ataxia is well known to follow cerebral malaria, but of five cases of this ataxia seen by the writer, only two had had cerebral malaria and all had had prolonged hyperpyrexia (temperature swinging to 109° for periods of 7 to 14 days), so that it was concluded that hyperpyrexia is the decisive factor.

Neurosurgery in such climates suffered from very great difficulties. On the Burma front neurosurgery was performed, in accordance with principles followed by the British in other theatres, by forward mobile neurosurgical units. Two of these had been in continuous operation for two years before I arrived, and another arrived in July and required considerable administrative attention to get it into action. Number 3 unit which I saw in action at Comilla during a busy period handled over 3000 cases in eighteen months. As soon as was practicable, cases were evacuated back to the neurosurgical center in Secunderabad in India for further study, late operation on bone defects, and disposal. Lt. Col. Richard Johnston has published a detailed account of the work of these mobile units (Lancet, 1945). From what I saw there might be mentioned, first, the difficulties relating to the temperature, for theater, preparation rooms and ward would all have to be air conditioned for comfort, and in forward areas air conditioning was a luxury which seldom applied to any of these. Local anesthesia could not be used for the patient could not tolerate the discomfort of any drapes if he were conscious, and the temperature well over 100° with 100 per cent humidity. The difficulty in persuading Sikhs to have their heads shaved (which their religion forbids) is another story. Finally, there was the stupendous problem of control of B. coli infection which invariably complicated all jungle penetrating skull wounds, and its eventual control by sulphamezathine in heroic dosage.

The management of paraplegia resulting from war wounds presented great difficulties owing to the great distances and the intolerance of high temperatures in this condition. Two points may be mentioned. First, the prevention of bed sores, in which I saw signs of success only after administrative instructions insisting on the earliest provision of one nursing orderly to each case, movement of the patient every twenty minutes, and strict avoidance of wetness of skin, had been issued. The patient and orderly were together evacuated to a paraplegic center by air. Second, the provision of paraplegic centers whose duty was to toughen sacral skin and lengthen its ability to stand one posture up to periods of two hours or more before wheel chairs and rehabilitation were begun. Suprapubic bladder drainage and lavage were used routinely with very satisfactory results.

It has been stated by some that poliomyelitis is almost unknown in India, but natives with flaccid asymmetrical atrophies dating from infancy are frequently seen, and after making enquiries of many physicians long resident in the country, I felt sure that it was endemic as an infantile disease. Young European Army officers were frequent victims and in the summer of 1945, despite a vigorous campaign of insect prevention and special precautions in the handling of food instituted by my predecessor, the incidence was half as much again as in 1944. Fecal contamination of water supplies is notorious throughout the East, and it was felt that this year precautions to secure absolute decontamination of excreta from all known cases would have been worth while. Meanwhile, with the end of the war, the repatriation of the susceptible Europeans has abolished the problem.

In early June, 1945, I examined a group of British ex-prisoners of war released from captivity in Rangoon. Their diet had much improved in the three months before release, and in 235 sick there was only one bad nutritional edema, a score of heliotrope tongues, several cases of recovering beri-

beri, one moderately severe. Mild nutritional edema of the ankles without abnormal neurological signs was common. The proportion of residual neurological disorder was therefore very small and the majority of these patients were suffering from malaria, chronic dysentery, and/or helminth infestation. Fourteen of these patients had a loss of vision sufficient to prevent their reading and the worst three of these were grossly ataxic in walking. One had bilateral nerve deafness. This disorder was quite distinct from beri-beri, and was described in Malaya in 1935 by Landor and Pallister who concluded that it was the result of a deficiency in part of the B-complex other than thiamin. It has been described in various parts of the world, by Scott in Jamaica in 1918, by Moore in West Africa in 1937, and cases had been observed in Hong Kong in 1940 and Egypt in 1944.

Following the surrender of the Japanese all European and Indian sick from the prison camps of Singapore, Malaya, Thailand, Indo-China, and Batavia were brought to India, and in 3600 of these I saw 185 cases of moderate or severe retrobulbar neuritis including 56 cases with ataxia and 10 with deafness, and 2 with laryngeal palsy. There were also a few instances of ataxia, deafness and laryngeal palsy, without retrobulbar neuritis. The detailed findings will be reported elsewhere. I have no doubt that this affection is a nutritional syndrome. Though it has been previously described in relation to pellagra, it was independent of the mucocutaneous lesions of ariboflavinosis and of niacin deficiency in the cases examined by me. The history of its onset obtained from records from Singapore and Batavian prison camps also demonstrated an incidence in place, time, and person that was different for this neurological syndrome and for beri-beri and muco-cutaneous disorders. Thiamin, riboflavin, and niacin had no effect in treatment. Some observers reported improvement in early stages with yeast extracts, but parenteral liver therapy gave the most striking improvement in our cases. Dietary surveys indicate that deficiency in animal protein was primarily at fault. Some Australian medical officers in Batavia reported improvement in the early stages when eggs could be added to the diet, an observation that suggests a deficiency in biotin.

This clinical experience and the additional observation of a group of patients with the spastic paraplegia of lathyrism emphasized the importance of nutritional factors in degenerative neurological disease, and gives a firmer conviction that the cause of more common chronic degenerative nervous diseases in colder climates will ultimately be determined.

The changed complexion of neurological medicine in the East is but part of the fascinating differences which there pervade clinical medicine as a whole, differences which throw additional light on the disorders of colder climates. The young graduate now going on service abroad for the first time, anticipating boredom through missing the excitement of war, should be assured that if he will use his initiative and curiosity a clinical experience that can enrich his whole medical career awaits him.





H. M. S. 1921
Front row center, left to right: Dr. Hale, Dr. Christian, Dr. Wolbach and Dr. Webber, Class President.

Twenty-fifth Reunion

The Class of 1921 held its 25th Reunion on Friday and Saturday, May 24th and 25th.

Those present were Dr. and Mrs.: Bauman, Blaisdell, Blumgart, Boyd, Buck, Byers, Castle, Curran, Dumphy, Fisher, Harrington, Hopkins, Hughes, Jones, Joslin, Kazanjian, Lugitch, Lydon, Macdonald, Mallory, Miller, Noyes, Sonnenburg, Sutton (Robert), Sziklas, Thorndike, Thurman, Townsend, Webber, White, and Drs.: Anderson, Bouvé, Haire, Hough, Kennedy, Liebman, Rees, Reese, Smith, Snelling, Vela-Gonzalez, Weyler, Woodbridge.

Letters were received from 23 classmates expressing regret at not being able to attend, a feeling which was shared by those present.

Fourteen members of the class have died since graduation.

Much of the success of the reunion was due to the determination of those classmates and their wives coming from a distance not to be prevented from arriving by the railroad strike. It was a great experience to hear from some of our teachers again and to come together and learn what had happened to us in the intervening years. We found that we were still comparatively young and still interested in each other. Our advice to other medical school classes is, "DON'T MISS YOUR 25TH."

★ Military News ★

The following list brings the Harvard Medical School graduates in the service up to 1928. The * denotes names not previously published. The list is continued here for those particularly interested in war records. Addresses are changing rapidly and many of the following will be out-of-date at the time of publishing.

1918

Capt. James B. Moloney, Navy, Fla. Group, 16th Fleet, Green Cove Springs, Fla.

1928

Comdr. David L. Halbersleben, U.S.N.H., Chelsea, Mass.

1929

Major Morris A. Bowie, 155th Sta. Hosp., APO 75, San Francisco

1931

Capt. A. Walter Benjamin Ciani, Wakeman Gen. Hosp., Camp Atterbury, Ind.

Capt. Raymond J. Connors, Navy, Quarters M, Quonset Point, R. I.

1934

Capt. Frederic W. Rhinelander, Letterman Gen. Hosp., San Francisco

Major William F. Stanek, Jr., Camp Carson, Col.

1936

Lt. Comdr. Clayton W. Nesbit, U.S.N.H., Newport, R. I.

Lt. Col. John W. Regan, 3d, Office of The Surgeon Gen., Washington, D. C.

Major Frederick E. Roach, Madigan Gen. Hosp., Ft. Lewis, Wash.

1937

Major Frederick J. Lesemann, Jr., 116th Gen. Hosp., APO 124, N. Y. C.

Major John A. Sandmeyer, Bushnell Gen. Hosp., Brigham City, Utah

1938

Capt. Lloyd Brown, Bruns Gen. Hosp., Santa Fe, N. Mex.

Capt. William B. Chamberlin, Jr., Army Med. Museum, Washington, D. C.

Lt. Col. Lucio E. Gatto, Air Surgeon's Office, Pentagon Bldg., Washington, D. C.

Comdr. Charles S. Hascall, Jr., U.S.N.H., Chelsea, Mass.

Comdr. Paul T. Moore, U.S.N.H., Newport, R. I.

Capt. Hugh Tatlock, Walter Reed Gen. Hosp., Washington, D. C.

Capt. Richard H. Upjohn, 161 Gen. Hosp., APO 851, Miami, Fla.

1940

Capt. Edward W. Boone, Sta. Hosp., Camp Chaffee, Ark.

Lt. Comdr. Robert H. Bradley, Jr., U.S.N.H., Philadelphia, Pa.

Capt. Addison G. Brenizer, Jr., 369th Gen. Hosp., APO, San Francisco

Lt. Donald A. Dupler, U.S.N.H., Philadelphia, Pa.

Lt. Comdr. Samuel E. Elmore, Jr., U.S.N. Academy, Annapolis, Md.

Capt. Bernard German, 12th Field Hosp., APO 228, N. Y. C.

Lt. Comdr. Carl M. McCandless, Jr., Hdqts. 2nd Med. Bn., 2nd Marines, FPO San Francisco.

Lt. Comdr. Bruce M. Shepard, U.S.N.H., Aiea, T. H.

1941

Lt. Comdr. John R. Dyke, U.S.N.H., Chelsea, Mass.

Lt. Arthur R. Hartwig, U.S.N.H., Chelsea, Mass.

Lt. Comdr. Egbert M. Hayes, N.A.A.S., Crows Landing, Calif.

Capt. Crawford H. Hinman, 1419 AAF Bn., APO 512, N. Y. C.

Lt. Comdr. Julian Nieckoski, U.S.N. Ammunitions Depot, McAlister, Okla.

Lt. Oliver K. Scott, Epidemiology Unit, 404 Embassy No. 2, APO 512, N. Y. C.

Lt. Comdr. Louis deS. Shaffner, Officer Sep. Cen., Washington, D. C.

Capt. Joseph C. Sherrick, 4th Med. Lab., APO 175, N. Y. C.

Lt. Comdr. Charles W. Sprunt, U.S.N.H., Philadelphia, Pa.

1942

Lt. Allen D. Callow, U.S.N.H., Newport, R. I.

Capt. Daniel R. Gray, Jr., AAF Reg. & Conv. Hosp., San Antonio, Tex.

Capt. John R. Newstedt, Disp. No. 7, R.T.C., Ft. Knox, Ky.

1943 (March)

Lt. Rockwood W. Bullard, Jr., Ft. Lawton, Seattle, Wash.

Capt. Bruce A. Harris, Jr., Sta. Hosp., Camp Shelby, Miss.

Capt. Joseph P. Holihan, 239th Gen. Hosp., APO, N. Y. C.

*Lt. Robert C. Jones, 20th Inf. Reg., APO 6, San Francisco

Capt. Irving M. London, USS McKinley, FPO, San Francisco
Capt. Dane G. Prugh, Camp Upton, N. Y.
Lt. Royal S. Schaaf, Post Surgeon's Office, Ft. Dix, N. J.
Capt. John C. Trakas, Walter Reed Gen. Hosp., Washington, D. C.
Lt. DeWitt S. True, U.S.N.H., Chelsea, Mass.
Lt. Frank C. Wheelock, Jr., 202nd Sta. Hosp., APO 732, Seattle, Wash.

1943 (December)

*Lt. Edwin F. Alston, Brooke Gen. Hosp., San Antonio, Tex.
Lt. Harrison Black, Ft. Sam Houston, Tex.
*Lt. (j.g.) Melvin B. Black, U.S.N.H., Jacksonville, Fla.
*Lt. Benjamin G. Ferris, Jr., Climatic Research Lab., Lawrence, Mass.
Lt. Fenimore T. Johnson, U.S.N.H., Jacksonville, Fla.
*Lt. James M. Judd, Mayo Gen. Hosp., Galesburg, Ill.
Lt. Elmer V. Kenneally, 1503 AAF Bn. Hamilton Field, Calif.
Lt. (j.g.) Alphonse H. Meyer, Jr., N.A.T.T.C., Memphis, Tenn.
*Lt. John M. Weller, Veterans Administration, Hines, Ill.

1944

*Lt. Charles D. Cook, Ft. Sam Houston, Tex.
*Lt. William J. Goade, Jr., Ft. Sam Houston, Tex.
Lt. John W. Harris, 279th Sta. Hosp., APO 755, N. Y. C.
*Lt. Richmond Holder, Ft. Sam Houston, Tex.
*Lt. Kenneth R. Kaess, AAF, Reg. & Conv. Hosp., San Antonio, Tex.
*Lt. (j.g.) D. Ralph Millard, Jr., Senior Med. Officer of Tenn. Recruiting, Nashville
*Lt. John C. Mithoefer, 1550 SCU Reg. Hosp., Ft. Knox, Ky.
*Lt. Mather Pfeiffenberger, Camp Carson, Col.
*Lt. Rafael Sanchez-Ubeda, Reg. Hosp., Ft. Knox, Ky.
*Lt. Robert W. Taylor, Jr., Bruns Gen. Hosp., Santa Fe, N. Mex.
*Lt. (j.g.) Earle W. Wilkins, Jr., U.S.N.H., Newport, R. I.

1945

*Lt. (j.g.) Eugene S. Austin, U.S.N.H., St. Albans, N. Y.
*Lt. (j.g.) Glenn E. Behringer, U.S.N.H., Portsmouth, N. H.
*Lt. Henry S. Bennett, Lovell Gen. Hosp., Devens, Mass.
*Lt. (j.g.) John M. Carey, U.S.N.H., Annapolis, Md.
*Lt. (j.g.) Charles W. Clarke, Jr., U.S.N.H., Bainbridge, Md.
*Lt. Giulio J. D'Angio, AAF Base Hosp., Mitchel Field, L. I.
*Lt. (j.g.) Stephen W. Cobb, U.S.N.H., Dublin, Ga.
*Lt. Frank P. Duffy, 104th AAF Bn., Mitchel Field, L. I.
*Lt. Alan A. Dun, AAF Reg. & Conv. Hosp., San Antonio, Tex.
*Lt. Walter R. Eberlein, Brooke Gen. Hosp., San Antonio, Tex.
*Lt. John M. Erskine, Dibble Gen. Hosp., Menlo Park, Calif.
*Lt. Nelson C. Fontneau, Jr., 104th AAF Bn., Mitchel Field, L. I.
*Lt. Dwight M. Fowler, Reg. Hosp., Ft. Benning, Ga.
*Lt. (j.g.) Judson S. Griffin, U.S.N.H., Mare Island, Calif.
*Lt. (jg.) Wade L. Grindle, Jr., U.S.N.H., Camp Pendleton, Calif.
*Lt. (j.g.) Buford Hall, Jr., U.S.N.H., Pensacola, Fla.
*Lt. (j.g.) William S. Hannan, Boston Naval Shipyard, Boston
*Lt. Edmund J. Harris, Camp Atterbury, Ind.
*Lt. Joseph P. Harvey, Jr., Reg. Hosp., Ft. Ord., Calif.
*Lt. Harry F. Hinckley, Jr., AAF Reg. Hosp., Mitchel Field, L. I.
*Lt. Carl S. Hoar, Jr., Pasadena Reg. Hosp., Pasadena, Calif.
*Lt. John E. Kiley, Baker Gen. Hosp., Martinsburg, W. Va.
*Lt. Charles A. Leach, Jr., Ft. Belvoir, Va.
*Lt. Martin Lubin, Waltham Reg. Hosp., Waltham, Mass.
*Lt. (j.g.) James A. Martin, U.S.N.H., Corpus Cristi, Tex.
Lt. Joseph M. Miller, Reg. Hosp., Ft. Belvoir, Va.
*Lt. (j.g.) John M. Packard, U.S.N. Disp., Washington, D. C.
*Lt. Raymond V. Randall, Surgeon General Office, Washington, D. C.
*Lt. Leonard J. Sagal, Wakeman Gen. Hosp., Camp Atterbury, Ind.
*Lt. Paul P. Salter, Jr., Reg. Hosp., Camp Lee, Va.
*Lt. David M. Sensenig, Mason Gen. Hosp., Brentwood, L. I.
**Lt. (j.g.) Frank P. Smith, Sep. Cen. N.A.S., Charleston, S. C.
*Lt. Richard W. Thaler, AAF Military Training Cen., San Antonio, Tex.
*Lt. Joseph B. Watrous, Jr., Reg. Hosp., No. 2, Ft. Bragg, N. C.
*Lt. Walter A. Wichern, Jr., Percy Jones Gen. Hosp., Battle Creek, Mich.
*Lt. Cecil W. Wooten, AAF, M.T.C., San Antonio, Tex.
*Lt. (j.g.) Bernard Zimmermann, Naval Medical Research Inst., Bethesda, Md.

Annual Meeting and Dinner

will be held in the

RED ROOM OF THE BOHEMIAN CLUB

SAN FRANCISCO

Wednesday, July 3, 1946 at 7 P. M.

(Note change of place)

ASSOCIATION OFFICERS
John H. Lawrence, *President*
Reginald Fitz, *Vice-President*
Clark W. Heath, *Secretary*
Franc D. Ingraham, *Treasurer*

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Mrs. K. B. Wilson, *Executive Secretary*
Harvard Medical School
Boston, Mass.

PROGRESS OF ASSOCIATION

At this time the officers of the Association are retiring, and it is pertinent to review briefly the progress which the Association has made during the past nine years. Dr. Reginald Fitz, who has served for six years as Vice-president, has led this development, helped by the sympathetic backing of the other officers and the Council. Nine years ago we were electing our officers and councillors locally at annual meetings held in Massachusetts. This worked well for the local management of the Association affairs, but it was scarcely a democratic process. In 1940, we voted to elect the President annually with the understanding that he would be selected from eminent alumni of the country at large. We also began to hold our annual meetings during the A.M.A. sessions. The following list gives the year of the recent annual meetings, the location and the President elected:

1940, New York City, Leslie L. Bigelow, '06, of Columbus, Ohio.

1941, Cleveland, Warren F. Draper, '10, of Washington, D. C.

1942, Atlantic City, William J. Kerr, '15, of San Francisco, Calif.

1943, Boston, Francis G. Blake, '13, New Haven, Conn. (A dinner was held this year at San Francisco).

1944, Chicago, Walter W. Palmer, '10, New York City.

1945, omitted, by ballot: John H. Lawrence, '30, Berkeley, Calif.

1946, (annual meeting to be in San Francisco. The officially nominated candidate is Earl D. Bond, '08, of Philadelphia, Pa.)

In 1942 we provided for the election of councillors by ballot, and by a method which allowed councillors to come from the country at large. It is to be hoped that in the future more democratic ways will be found to bring the alumni closer together, to propose officers and councillors for election or in other ways to make the Association more representative.

In the meantime the functions of the Alumni Office in Building A of the Medical School have been enlarged and improved. Much of this has been due to the devoted interest of our Executive Secretary, Mrs. K. B. Wilson. When alumni visit Boston or when they need information or help in one way or another, they can utilize the facilities of this office. Here are kept the files of alumni, the alumni notes, the war records, and the files of the Bulletin. Each year the office makes the arrangements for 8 to 12 class reunions and for the annual meetings and the handling of funds for aiding the students and other functions of the Association.

Vigorous attempts to make the Bulletin of more interest and usefulness to alumni have been made. Much of its recent attractiveness is due to the work of the assistant editor, Dr. Francis Moore, who has been chiefly responsible for format and the Medical School Notes. We believe that the in-coming editor will have a sound basis for making the Bulletin a still more attractive journal.

The response of alumni to appeals has been increasing with the years and has been very gratifying. It is this interest which can have a very important influence upon the Medical School, providing it with a strong, unified alumni body, ready to assist in time of need.